Healthpoint

Information from the Division of Health Care Finance and Policy

MARKET CHANGE AFFECTS COMMUNITY HEALTH CENTERS

Community health centers (CHCs) provide a crucial link to health services for lower income individuals throughout Massachusetts. Despite tremendous change in the Commonwealth's health care market recently, the mission of these organizations remains largely the same since their founding three decades ago. A key component of the state's safety net, CHCs provide accessible, high quality primary care services to low income residents regardless of ability to pay.

CHCs always depended on hospitals, usually municipal safety net hospitals, to provide an inpatient site for their sick patients. This relationship reflected a relative lack of interest by private non-profit hospitals in CHCs' often uninsured patients. However, seismic changes in the Massachusetts health care industry in the early 1990s created new negotiating opportunities for Boston CHCs. This issue of *Healthpoint* examines this evolution with specific attention to whether more involvement with CHCs by private non-profit hospitals has served the hospitals, the CHCs, and above all the patients. To prepare this analysis, the Division of Health Care Finance and Policy conducted extensive interviews with a variety of interested parties, including hospital administrators, CHC directors, and patient advocates.

A continuum of different partnership arrangements is possible between CHCs and hospitals. Under the tightest arrangement, a hospital may directly license a CHC, budgeting and administering it as any other hospital department. Alternatively, a variety of affiliation agreements are negotiated with greater or lesser exclusivity and interdependence. One noticeable trend examined here is more formal arrangements between CHCs and hospitals spurred at least in part by the promise of substantial capital investment in certain CHCs by hospitals.

Hospitals Seek Stronger Ties

A number of factors explain the dramatic change in the worth of CHCs to hospitals. The most important impetus, market consolidation, started in the acute sector but eventually rippled through the industry. The announcement of the creation of Partners

Massachusetts Community Health Centers
46 Centers at 99 Sites

Location	Ownership
28 in Boston	30 free-standing
18 in the rest of the state	16 hospital licensed

628,000 patients served
3 million patient visits
$312.5 million in total revenue*

*Note: see Figure 1 on page 2 for a breakdown of revenue sources
Source: Massachusetts League of Community Health Centers, 1998

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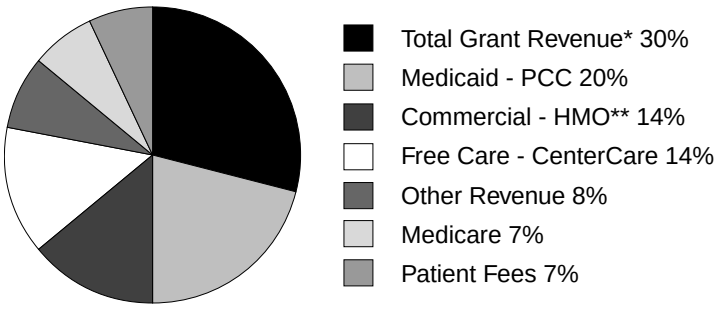
HealthCare System in December 1993 was the catalyst that eventually resulted in reactive alliances throughout the state. Partners, and subsequently other systems, pursued a strategy of consolidating market power in an effort to create efficiency, reduce costs, and ensure patient stream. Only by taking these steps could the systems strengthen their own negotiating capacity with the increasingly dominant managed care organizations. Lining up "covered lives" by linking with CHCs and physician practices was an important strategy for surviving under managed care capitation agreements. CHCs gained negotiating pull as hospital systems scrambled to broaden and integrate their own networks. Compared to the purchase of physician practices (which the private non-profit hospitals also did), CHC affiliations provided hospitals the opportunity to expand their primary care practice and garner referrals while assuming significantly less risk and tapping into a different market base.

Second, several CHC administrators cite a report commissioned by the Boston Department of Health and Hospitals as setting the stage for hospitals to increase involvement in community health even before market forces compelled that strategy. This 1993 report, by Professor Nancy Kane of the Harvard School of Public Health, charged that private non-profit hospitals were understating profits and that the weakest hospitals financially made the strongest commitment to Boston's poor. Moral pressure generated by the Kane report added fuel to a growing interest in community benefits. During this period, a few non-profit hospitals in other states lost tax exempt status over this issue and six states including California enacted community benefit mandates. These developments led to the introduction of legislation in Massachusetts calling for hospitals to provide funding to health centers and, ultimately, to the creation of voluntary community benefit guidelines. For many hospitals, relationships with CHCs serve as a cornerstone for fulfilling these obligations.

A number of interviewees also believe that MassHealth expansions and full funding of the Uncompensated Care Pool have strengthened the negotiating clout of CHCs. The former extends insurance coverage to otherwise uninsured residents and the latter reimburses providers nearly at cost for their uninsured patients. Since July 1997, more than 200,000 individuals have enrolled in MassHealth as a result of state reform efforts, increasing total enrollment by 37% as of March 1999.[1] In this era of sustained pressure to reduce both admissions and lengths of stay, hospitals view these patients as a viable means of maintaining occupied beds. Moreover, expansion of the Uncompensated Care Pool in 1992 allowed CHCs to access free care reimbursement quelling hospital anxiety regarding the fiscal solvency of potential CHC affiliates.

Massachusetts Community Health Centers
FY98 Sources of Revenue



*Includes federal, state, local, and other grants
**Includes NHP and other Medicaid HMO enrollments
Source: Mass. League of Community Health Centers and US Bureau of Primary Health Care (UDS)

Figure 1

Cinderella Centers

From the CHC perspective, fiscal considerations figured prominently in their interest in pursuing stronger hospital partnerships. CHCs regularly operate with minimal cash reserves and lack resources to undertake capital improvements. They viewed the perceived deep

pockets of hospitals as a means of financing new facilities and capital intensive information systems. Through spirited bidding among interested hospital suitors for affiliation contracts, Boston CHCs negotiated for needed project underwriting. In fact, one concrete result of market consolidation is the rebuilding of many Boston area health centers financed significantly by hospitals. This flurry of hospital investment activity prompted a *Boston Globe* reporter to characterize Boston CHCs as "Cinderella centers" in late 1995.[2] Despite these substantial investments, however, CHCs report no pressure to dilute the composition of their community-based boards of directors with hospital personnel.

Health center administrators outside the Boston area portrayed a starkly different experience with their area hospitals. The courting frenzy that benefited the Boston area CHCs simply did not occur elsewhere. The difference appears to lie in the much lower level of hospital competition outside Boston. A health center located in a market dominated by a single hospital system continues to exercise little bargaining power in the absence of choice for affiliation. Conversely, no incentive exists for a dominant hospital to court a health center. While no CHC administrators outside Boston claim to be *worse off* in the aftermath of market consolidation, they never received the offers of capital infusion enjoyed by Boston-based CHCs.

Have Patients Benefited?

Boston health centers identify numerous improvements in patient care resulting from tighter affiliations with hospitals. Specifically, affiliations facilitate improved coordination and communication with hospital-based specialists, in part through the upgrading and integrating of CHC information systems. Computer linkages now support shared medical records and facilitate jointly run public health initiatives. For example, one Boston health center and its hospital partner collaborate on a breast cancer screening data collection initiative. Through this effort, they hope to establish a baseline of current utilization and to evaluate barriers to access.

Such collaborations represent the potential benefits hospital affiliation can bring to CHC clinical capacity. Increasing on-site specialty care, expanding women's health services, and rotating medical school students and residents through the health centers all benefit patient care. Early concern that affiliation contracts could lead to the curtailing of referral choice has not materialized. CHC administrators also note the advantage of access to the tremendous purchasing power of hospitals. Finally, hospital administrators recognize that CHCs teach them valuable lessons about providing culturally appropriate care to diverse populations which also ultimately improves patient care.

On the other hand, CHC administrators say that the same systemic change that brought increased market power to them has made navigating through the system more difficult for their patients, as it has for all managed care patients. Managed care requirements such as obtaining permission for specialist or emergency care are particularly difficult for individuals with language difficulties or limited education.

Policy Implications

Transformation of the hospital industry played the predominant role in advancing CHC negotiating power in the Boston marketplace. The impetus behind market consolidation traces back to deregulation of the hospital industry by the state legislature and the double-digit health care spending growth of the early 1990s. These dynamics resulted in the explosive growth of managed care plans, thereby greatly increasing insurer negotiating power. In reaction, two of the largest hospitals in the state formed an historic partnership to gain a stronger hand with managed care. This alliance,

at the time described as a "stunning" development[3] by the *Boston Globe*, set the stage for competitors to reactively follow suit and feverishly seek out primary care alliances. In turn, this led to the strengthening of CHC negotiating power in the Boston area.

The underlying policy of state government throughout these events was a hand off to market forces. This policy benefited CHCs able to harness market forces to increase financial stability and augment clinical resources without significantly compromising their historic mission. However, its result elsewhere in the state is less sanguine. Generally, the local dominance of single hospital systems eliminated the need to bid for CHC favor. This dynamic bears monitoring to ensure that non-metropolitan CHCs do not falter as resources become increasingly strained.

Another policy question is to what degree do community benefit guidelines affect CHCs. After only a few years, formal evaluation of this voluntary program may be premature. However, preliminary anecdotal evidence suggests that, at minimum, guidelines raise the profile and the bar for community involvement by hospitals. In the words of one administrator, voluntary guidelines "add community benefits to the checklist of issues hospitals need to be concerned about."

However, the strength of voluntary guidelines and the depth of hospitals' philosophical commitment to CHCs will be tested in an era of constrained resources. As cuts from the Balanced Budget Act of 1997 and slimmer margins take their toll, will Boston CHCs continue to enjoy their favored status with hospitals? Will competition for primary care patients increasingly pit a CHC against its affiliated hospital's primary care medical staff or its purchased medical practice? As the health care market continues to evolve rapidly, policymakers should monitor CHCs to ensure that they can continue to meet the particular health needs of their often vulnerable communities.

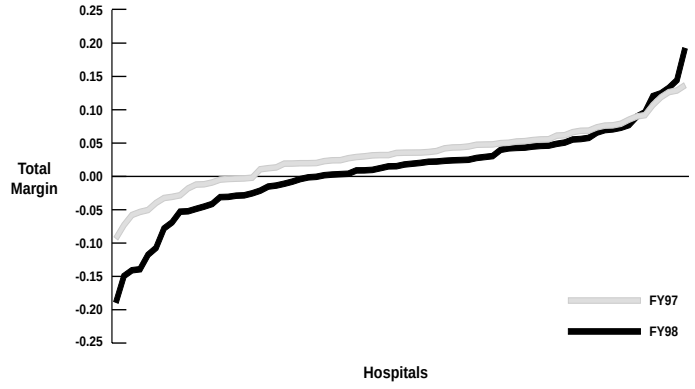
Endnotes

1. Source: Massachusetts Division of Medical Assistance, March 1999.
2. Pham, Alex. "Cinderella Centers: Community Health Clinics Expand with Recent Cash Infusions for Hospitals." *Boston Globe*. October 31, 1995.
3. Knox, Richard A. "New Name, New Slant on Hospital 'Merger.'" *Boston Globe*. March 22, 1994.

Did you know?

Hospital Margins Decreased Between 1997 and 1998

The ratio of total profit to total expense (total margin) for the Massachusetts acute care hospital industry showed an overall decrease from 1997 to 1998 and more hospitals had negative total margins in 1998. The most profitable hospitals in 1997 were the same as those in 1998, and performed even better. The least profitable hospitals in 1998 were different than those in 1997 and showed even lower margins. A soon to be released DHCFP report will evaluate the overall financial health of the hospital industry.



Notes: Data reported on 71 hospitals for 1997 and 1998. Data for 1998 is considered "as filed" and subject to further audit.
Source: DHCFP 403 Hospital Cost Report, Schedule 23.

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